



FUEL _{Rx} FITNESS, INC.

Health/Medical Questionnaire

Date: _____

Name: _____ Date of Birth: _____ Soc Sec #: _____

Address: _____
Street City State Zip

Phone (H): _____ (W): _____ E-Mail address: _____

In case of emergency, whom may we contact?

Name: _____ Relationship: _____

Present/Past History

Have you had OR do you presently have any of the following conditions? (Check if YES.)

- Rheumatic fever
- Recent operation
- Edema (swelling of ankles)
- High blood pressure
- Injury to back or knees
- Low blood pressure
- Seizures
- Lung Disease
- Heart attack
- Fainting or Dizziness
- Diabetes
- High Cholesterol

- Orthopnea (The need to sit up to breathe comfortably) or Paroxysmal (sudden, unexpected attack) Nocturnal dyspnea(shortness of breath at night)
- Shortness of breath at rest or with mild exertion
- Chest pains
- Palpitations or tachycardia (unusually strong or rapid heartbeat)
- Intermittent claudication (calf cramping)
- Pain, discomfort in the chest, neck, jaw, arms, or other areas
- Known heart murmur
- Unusual fatigue or shortness of breath with usual activities
- Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body
- Other _____

Family History

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.) In addition, please identify at what age the condition occurred.

- Heart attack Age _____
- Heart operation Age _____
- Congenital heart disease Age_____
- High blood pressure Age_____
- High Cholesterol Age_____
- Diabetes Age_____
- Other major illness _____ Age_____

Explain checked items: _____

Activity History

1. How were you referred to this program? (Please be specific.) _____

2. Why are you enrolling in this program? (Please be specific.) _____

3. Are you presently employed? Yes ___ No___

4. What is your present occupational position? _____

5. Name of company: _____

6. Have you ever worked with a personal trainer before? Yes ___ No ___

7. Date of your last physical examination performed by a physician: _____

8. Do you participate in a regular exercise program at this time? Yes___ No___ If yes, briefly describe:

9. Can you currently walk 4 miles briskly without fatigue? Yes___ No___

10. Have you ever performed resistance training exercises in the past? Yes___ No___

11. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes___ No___ If yes,
Briefly describe: _____

12. Do you smoke? Yes ___ No ___ If yes, how much per day and what was your age when you started?

Amount per day_____ Age_____

13. What is your body weight now? _____ What was it a year ago? _____ At age 21? _____

14. Do you follow or have you recently followed any specific dietary intake plan, and in general how do you feel
About your nutritional habits? _____

15. What are your favorite foods to eat? (Please note both nutritional and non-nutritional foods/drinks)

16. List the medications you are presently taking. _____

17. List in order your personal health and fitness objectives.

a. _____

b. _____

c. _____

d. _____

e. _____